

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF CALIFORNIA

KAISER FOUNDATION HOSPITALS, a  
California Nonprofit Public Benefit  
Corporation, d/b/a Kaiser Permanente  
San Francisco Medical Center,

Plaintiff,

v.

MICHAEL O. LEAVITT, Secretary of the  
United States Department of Health  
and Human Services,

Defendant.

No. C 05-3143 CW

ORDER ON CROSS-  
MOTIONS FOR  
SUMMARY JUDGMENT

Plaintiff Kaiser Foundation Hospitals moves for summary judgment. Defendant Michael O. Leavitt, Secretary of the United States Department of Health and Human Services, opposes this motion and cross-moves for summary judgment. Plaintiff opposes that motion. As Defendant notes, although the parties have styled their papers as cross-motions for summary judgment, this is a proceeding for judicial review of a final administrative decision. Plaintiff seeks to set aside Defendant's decision setting its Medicare

1 reimbursement rate for kidney dialysis treatment at \$212.81;  
2 Plaintiff contends that its reasonable cost is \$476.15 per  
3 treatment. The parties appeared before the Court on September 8,  
4 2006, and agreed that the case should be decided on the record,  
5 without a trial. Having considered the parties' papers, the record  
6 and oral argument, the Court grants both Plaintiff's and  
7 Defendant's motions in part and denies each in part.

#### 8 BACKGROUND

9 Plaintiff is a non-profit public benefit corporation that  
10 operates Kaiser Permanente San Francisco Medical Center, a  
11 Medicare-certified hospital located in San Francisco, California.  
12 The Kaiser Permanente San Francisco Medical Center treats patients  
13 with End Stage Renal Disease (ESRD), an irreversible kidney  
14 impairment requiring blood filtering dialysis or kidney transplant;  
15 if untreated, ESRD is life-threatening. One of the services  
16 covered under Medicare is outpatient kidney dialysis for patients  
17 with ESRD. Persons with ESRD qualify for services under Medicare  
18 regardless of their age; nearly all, if not all, ESRD patients are  
19 Medicare patients.

20 Through the Health Care Financing Administration (HCFA),<sup>1</sup> the  
21 agency that administers the Medicare program, Health and Human  
22 Services provides Medicare reimbursements to providers, such as  
23 Plaintiff, for outpatient ESRD treatments for qualifying Medicare  
24 patients. Previously, providers were reimbursed by Medicare for

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26 <sup>1</sup> As Plaintiff notes, the facts relating to this appeal  
27 occurred before the HCFA was renamed Centers for Medicare and  
28 Medicaid Services (CMS). For convenience, the Court will use HCFA  
to refer to, and include, CMS.

1 outpatient ESRD services on a reasonable cost basis. But, under  
2 the Omnibus Budget Reconciliation Act of 1981, the reasonable cost  
3 reimbursement was replaced by a prospectively determined rate of  
4 reimbursement for each dialyses treatment. Pub. L No. 97-35; 42  
5 U.S.C. § 1395rr(b)(7) (1982).<sup>2</sup> According to this new reimbursement  
6 process:

7       The Secretary shall provide by regulation for a method (or  
8       methods) for determining prospectively the amounts of payments  
9       to be made for dialysis services furnished by providers of  
10      services . . . . Such method (or methods) shall provide for  
11      the prospective determination of a rate (or rates) for each  
12      mode of care based on a single composite weighted formula  
13      (which takes into account the mix of patients who receive  
14      dialysis services at a facility or at home and the relative  
15      costs of providing such services in such settings) for  
16      hospital-based facilities and such a single composite weighted  
17      formula for other renal dialysis facilities, or based on such  
18      other method or combination of methods which differentiate  
19      between hospital-based facilities and other renal dialysis  
20      facilities and which the Secretary determines, after detailed  
21      analysis, will more effectively encourage the more efficient  
22      delivery of dialysis services and will provide greater  
23      incentives for increased use of home dialysis than through the  
24      single composite weighted formulas. The Secretary shall  
25      provide for such exceptions to such methods as may be  
26      warranted by unusual circumstances.

17 Pub L. No. 97-35; 42 U.S.C. § 1395rr(b)(7).

18       Pursuant to this authority, Health and Human Services adopted  
19      regulations for reimbursement of outpatient ESRD services based on  
20      a "composite" or prospectively determined per-treatment rate. In  
21      addition, HCFA promulgated various provisions in a Provider  
22      Reimbursement Manual. Under these regulations and provisions,  
23      providers have to accept the prospective payment determined by HCFA  
24      as payment in full for covered outpatient maintenance dialysis.

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26       <sup>2</sup>All references to 42 U.S.C. § 1395rr and sections of Title 42  
27      of the Code of Federal Regulations are to their respective versions  
28      in effect at the time of the events at issue.

1 But the regulations and provisions also provide a process  
2 through which providers can request an exception to the standard  
3 composite rate, resulting in a higher per-treatment rate. The  
4 provider begins the process by filing a request with its Medicare  
5 fiscal intermediary, which then reviews and makes recommendations  
6 on rate exception requests and forwards requests to HCFA. If HCFA  
7 does not deny a rate exception request within sixty working days,  
8 the rate exception request is deemed approved. Under 42 C.F.R.  
9 § 413.170(g), HCFA approves an exception to the prospective payment  
10 rate when the provider "demonstrates with convincing objective  
11 evidence that its total per-treatment costs are reasonable and  
12 allowable under § 413.174, and that its per-treatment costs in  
13 excess of its payment rate are directly attributable" to "atypical  
14 service intensity." After approval, the exception rate is provided  
15 for a predetermined period of time; then the provider has to file a  
16 new exception request. HCFA's determinations on ESRD composite  
17 rate exception requests are subject to review by the Provider  
18 Reimbursement Review Board (the Board), consisting of five  
19 individuals knowledgeable in reimbursement matters. The Board's  
20 decision is subject to review by the HCFA Administrator, who can  
21 reverse, modify or adopt the Board's decision. The Administrator's  
22 decision is final, subject to district court review.

23 In 1987 and 1988, Plaintiff submitted exception requests,  
24 contending that, because it exclusively treated an atypical patient  
25 population, it was entitled to payment higher than the standard  
26 composite rate. The HCFA denied most of Plaintiff's exception  
27 requests. On review, however, the Board found that Plaintiff

1 exclusively served an atypical patient population and had done so  
2 since its inception in 1969 or 1970; it granted Plaintiff most of  
3 the costs requested in the exception requests. As part of a  
4 settlement agreement between Plaintiff and Aetna Life and Casualty  
5 Company, HCFA agreed to pay Plaintiff \$250 per dialysis from the  
6 date of Plaintiff's first exception request, March 24, 1987. HCFA  
7 continued to pay Plaintiff \$250 per dialysis treatment until  
8 April 29, 1994.

9 At the end of 1993, HCFA informed Plaintiff that it was  
10 reopening the exception process and that Plaintiff could request a  
11 new exception rate by submitting an exception request on or before  
12 April 29, 1994. Providers which did not submit an exception  
13 request would be limited to \$139 per treatment.

14 On March 22, 1994, Plaintiff filed its seventh exception  
15 request. It was returned by the intermediary who indicated that  
16 additional and modified information was needed. On April 21, 1994,  
17 Plaintiff submitted its revised exception request, seeking \$337.15  
18 over and above the composite rate of \$139 for a total reimbursement  
19 of \$476.15 per treatment. The 1994 exception request, which is the  
20 basis of Plaintiff's challenge, was based on the following:

21 1. Plaintiff projected that it would incur \$187.67 in labor  
22 costs per treatment, including the salary and employee benefits for  
23 the registered nurses, nursing supervisor, clinical dietician, unit  
24 assistant and physician medical director; the labor component of  
25 the composite rate was \$47.

26 2. Plaintiff projected that it would incur \$51.82 in supply  
27 costs; the supplies component of the composite rate was \$33.

1       3. Plaintiff projected that it would incur \$239.66 in  
2 overhead costs; the overhead component of the composite rate was  
3 \$47.

4       HCFA found that Plaintiff "presented convincing evidence that  
5 it rendered a substantial number of treatments to patients  
6 requiring more intense care during outpatient maintenance dialysis  
7 service, and that it incurs higher than average per-treatment costs  
8 for rendering these intense services." AR 1037. But, HCFA only  
9 granted Plaintiff a rate of \$199.56. AR 1040. That rate consisted  
10 of the \$139.00 as the base composite rate plus \$46.33 for  
11 additional salaries, \$8.66 for additional employee benefits, and  
12 \$5.57 for additional supplies. HCFA explained that, in accordance  
13 with section 2721.B of the Provider Reimbursement Manual,<sup>3</sup>

14       when a facility submits documentation that does not identify  
15 both the specific additional items and/or services rendered  
16 which are in addition to a routine dialysis service and the  
17 incremental costs of these items and/or services, that  
18 facility will not qualify for an exception under the atypical  
19 patient mix criterion. Therefore, we are unable to recognize  
20 these high costs for an exception to the composite rate.

21 Id.

22       Not satisfied with \$199.56, which was less than half of what  
23 it requested, Plaintiff appealed HCFA's determination to the Board.  
24 After an evidentiary hearing, the Board granted Plaintiff a rate of  
25 \$299.93.

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26       <sup>3</sup>Section 2721.B of the manual provides:

27       The facility must provide written justification for supporting  
28       the facility's higher costs. The fact that a facility  
      projects costs higher than its composite rate payment is not  
      adequate documentation for granting an exception. The  
      facility must provide HCFA with supporting material  
      documenting the reasons that may justify its costs in excess  
      of its composite payment rate.

1 Specifically, the Board found that, with respect to labor  
2 costs, HCFA erred in calculating the cost of nursing hours. HCFA  
3 divided nursing salaries by "nursing hours paid" to determine the  
4 average hourly nursing rate. It then multiplied that rate times  
5 the "nursing hours worked" on dialysis treatments to calculate the  
6 costs per treatment for nursing salaries. While "nursing hours  
7 paid" included hours worked, as well as hours of paid vacation,  
8 holiday and sick time, "nursing hours worked" did not account for  
9 vacation, holiday and sick time earned for those hours. The Board  
10 concluded that, by using nursing hours paid in calculating the  
11 hourly rate and but using nursing hours worked in calculating the  
12 reimbursement amount, the HCFA improperly failed to reimburse the  
13 vacation, sick and holiday time Plaintiff paid to its nursing  
14 staff. Correcting that error, the Board determined that Plaintiff  
15 was entitled to an exception amount of \$62.13 for nursing salaries,  
16 \$15.80 more than the additional \$46.63 the HCFA granted.

17 With respect to non-nursing labor cost, the Board found that  
18 Plaintiff submitted sufficient documentation to support some of its  
19 claims. For example, the Board determined that Plaintiff was  
20 entitled to an additional \$1.55 per treatment for the services of a  
21 clinical dietitian and an additional \$4.95 per treatment for  
22 administrative support. But the Board denied any additional  
23 reimbursement for management costs, finding that Plaintiff did not  
24 provide convincing evidence that additional management costs were  
25 attributed to patient atypicality.

26 The Board further found that, in calculating the exception  
27 amount for employee benefits, HCFA should not have used the  
28

1 national average employee benefit percentage and instead should  
2 have used Plaintiff's actual employee benefit percentage. Using  
3 the actual benefit percentage, the Board found that the exception  
4 amount should be \$15.28 per treatment.

5 With respect to supply costs, the Board found that Plaintiff  
6 provided specific rationale and data to support its additional  
7 supply costs; it approved \$51.82 in supply costs, the entire amount  
8 Plaintiff requested.

9 As for overhead costs, the Board found that, for Medicare cost  
10 reporting purposes, the cost of delivering services includes the  
11 direct costs incurred for labor and supplies and the indirect  
12 costs, or overhead, incurred for such expenses as administrative  
13 and general costs, housekeeping, equipment, laundry and linen. The  
14 Board agreed with Plaintiff that Plaintiff had "presented evidence  
15 that its overhead costs are related to the atypical patients, and  
16 that there is no such incremental requirement in the Medicare  
17 regulations and Manual provisions." AR 98. Concluding that it is  
18 not possible to link overhead costs directly to a particular  
19 service, the Board ruled that Plaintiff was entitled to a 56.5  
20 percent overhead exception amount, totaling \$105.20, for all  
21 approved direct cost exception amounts. The Board calculated the  
22 56.5 percent by dividing 47, which represents the \$47 composite  
23 rate for indirect overhead costs, by 83, which represents the \$83  
24 composite rate for direct costs.

25 HCFA requested review of the Board's decision, arguing that  
26 the Administrator should reverse the decision. Plaintiff submitted  
27 a letter to the Administrator requesting that the Administrator  
28

1 modify the Board's opinion to grant it the full amount of its  
2 requested exception to the ESRD composite rate. The Administrator  
3 agreed to review the Board's decision.

4 After reviewing the comments provided by Plaintiff and HCFA,  
5 the Administrator issued his decision, the final agency decision,  
6 granting Plaintiff a \$212.81 per-treatment ESRD exception rate.  
7 Like the Board, the Administrator found that the record supported  
8 the finding that Plaintiff serves an atypical patient mix  
9 population. After reaching that conclusion, however, the  
10 Administrator stated that "in addition to demonstrating that it  
11 serves an atypical patient mix, the Provider must also demonstrate,  
12 inter alia, that the costs are reasonable and that the elements of  
13 excessive costs are specifically attributable to the Provider's  
14 atypical patient mix." AR 9. The Administrator concluded that,  
15 for the most part, Plaintiff failed to show that the costs are  
16 specifically attributable to the atypical patient mix, and affirmed  
17 only the Board's determination on supply costs.<sup>4</sup>

18 With respect to nursing labor salary costs, the Administrator  
19 disagreed with the Board's determination, stating that HCFA "has  
20 consistently used 'nursing hours worked' to determine the average  
21 nursing hours per treatment and 'nursing hours paid' to determine  
22 the average hourly rate for an ESRD unit." AR 9. Concluding that  
23 there is nothing inherently inconsistent in this methodology, the  
24 Administrator determined that Plaintiff was entitled to an  
25 exception of only \$46.33 for nursing salaries.

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26  
27 <sup>4</sup>Neither party contests the Administrator's conclusion  
28 regarding supply costs.

1 The Administrator further determined that HCFA properly  
2 concluded that the excess cost of non-nursing labor should not be  
3 included in the exception because Plaintiff failed to provide  
4 written justification supporting its higher costs.

5 With respect to employee benefits, the Administrator reversed  
6 the Board's decision, concluding that HCFA did not improperly deny  
7 Plaintiff's full exception for excess employee benefits. The  
8 Administrator again concluded that Plaintiff failed to show that  
9 the extra costs are specifically attributable to its atypical  
10 population mix: "As reflected by the record, the Provider's  
11 exception request is absent of documentation which links the  
12 excessive employee benefits costs" above the 18.7 percent national  
13 employee-benefits average. AR 10.

14 The Administrator also reversed the Board's decision  
15 concerning overhead costs, again concluding that Plaintiff failed  
16 to substantiate its claims that excess overhead costs directly  
17 relate to its atypical patients. The decision stated:

18 That Administrator finds that the Provider's general contention  
19 that certain overhead costs must follow higher direct costs is  
20 contrary to the specific requirements of the regulations and  
21 manual and likewise is not supported by the record. Contrary  
22 to the specific regulatory requirements and PRM instructions,  
23 the Provider offered no documentation, other than general  
statements, to identify its higher overhead costs and the link  
to its atypical patient mix. Simply because the Provider has  
an atypical patient mix does not demonstrate that its overhead  
costs are "directly attributable" to the provision of atypical  
services.

24 AR 13.

25 Plaintiff now seeks judicial review of this final decision,  
26 and requests that the Court overturn that decision and grant the  
27 full amount of the exception it seeks, \$476.15 per treatment.

## STANDARD OF REVIEW

The Court reviews Plaintiff's challenge to the final decision under the Administrative Procedure Act (APA). 42 U.S.C. § 1395oo(f)(1); 5 U.S.C. § 706. Under the APA, courts "hold unlawful and set aside" only agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); Thomas Jefferson University v. Shalala, 512 U.S. 504, 512 (1994). The Supreme Court instructs that courts "must give substantial deference to an agency's interpretation of its own regulations." Thomas Jefferson University, 512 U.S. at 512. In reviewing a plaintiff's challenge, a court's "task is not to decide which among several competing interpretations best serves the regulatory purpose. Rather, the agency's interpretation must be given controlling weight unless it is plainly erroneous or inconsistent with the regulation." Id. (inner quotations and citation omitted). Thus, the Supreme Court requires courts to "defer to the Secretary's interpretation unless an 'alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation.'" Id. (quoting Gardebring v. Jenkins, 485 U.S. 415, 430 (1988)).

Although a court's review of a plaintiff's challenge is a "narrow one," it is required to "engage in a substantial inquiry" and conduct "a thorough, probing, in-depth review." Native Ecosystems Council v. U.S. Forest Serv., 418 F.3d 953, 960 (9th Cir. 2005) (quoting Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 415-16 (1971), overruled on other grounds by

1 Califano v. Sanders, 430 U.S. 99, 105 (1977)). To determine  
2 whether an agency action was arbitrary and capricious, the court  
3 must "determine whether the agency articulated a rational  
4 connection between the facts found and the choice made." Ariz.  
5 Cattle Growers' Ass'n v. U.S. Fish and Wildlife, 273 F.3d 1229,  
6 1236 (9th Cir. 2001). As long as the agency decision was based on  
7 a consideration of relevant factors and there is no clear error of  
8 judgment, the reviewing court may not overturn the agency's action.  
9 Id. (citing Am. Hosp. Ass'n v. NLRB, 499 U.S. 606 (1991)). In  
10 particular, the reviewing court must defer to the agency's decision  
11 when the resolution of the dispute involves issues of fact or when  
12 a complex and highly technical regulatory program, like Medicare,  
13 is involved. Thomas Jefferson Univ., 512 U.S. at 512; see also  
14 Marsh v. Or. Natural Res. Council, 490 U.S. 360, 377 (1989).  
15 Accordingly, the court may set aside only those conclusions that do  
16 not have a basis in fact, not those with which it merely disagrees.  
17 Ariz. Cattle Growers' Ass'n, 273 F.3d at 1236.

## DISCUSSION

18  
19 Plaintiff argues that it has met all the requirements for  
20 receiving an ESRD exception in the full amount it requested by  
21 showing that its increased costs are reasonable and directly  
22 attributable to its atypical patients. Its argument rests, in  
23 part, on the definition of the phrase "directly attributable." The  
24 Court first addresses Plaintiff's challenge to the meaning of that  
25 phrase before addressing the two categories of contested costs:  
26 labor and overhead. The Court will then address Plaintiff's  
27 argument that Defendant's decision to grant Plaintiff an exception

1 of less than \$250 per treatment is arbitrary and capricious.

2 I. "Directly attributable"

3 To be granted an exception, a provider must demonstrate "with  
4 convincing objective evidence" that its per-treatment costs are  
5 reasonable and "directly attributable" to an atypical patient mix.  
6 42 C.F.R. § 413.170(f)(6). The phrase "directly attributable,"  
7 which is used synonymously with the phrase "specifically  
8 attributable," however, is not expressly defined in the Medicare  
9 regulations or provisions. Plaintiff argues that, because  
10 "directly attributable" is not defined, the Court should construe  
11 the term in accordance with its "common meaning," and as Plaintiff  
12 believes it should be construed. See Cleveland v. City of Los  
13 Angeles, 420 F.3d 981, 989 (9th Cir. 2005) ("To determine the  
14 meaning of a term in a federal regulation, we look to the common  
15 meaning of the word.").

16 Plaintiff minimizes the deference owed to Defendant's  
17 interpretation, especially in cases involving Medicare's "complex  
18 and highly technical regulatory program." Alhambra Hospital v.  
19 Thompson, 259 F.3d 1071, 1074 (9th Cir. 2001). Instead, citing  
20 Alhambra Hospital, Plaintiff argues that an agency is not entitled  
21 to deference where a regulation is plain on its face. In Alhambra  
22 Hospital, the Ninth Circuit instructed that courts "must defer to  
23 an agency's interpretation unless an 'alternate reading is  
24 compelled by the regulation's plain language.'" 259 F.3d at 1074  
25 (quoting Thomas Jefferson Univ., 512 U.S. at 512). Here, an  
26 alternate reading is not compelled by the plain language of the  
27 term.

1 As Plaintiff acknowledges, there are numerous definitions for  
2 the word "directly," and thus various "common meanings." Plaintiff  
3 uses the definition "without anyone or anything intervening" found  
4 in the American Heritage College Dictionary (3d Ed. 1997), noting  
5 that the word is synonymous with immediately. Another definition  
6 for "directly" is "exactly; precisely." See Random House College  
7 Dictionary (1982). Plaintiff states that the plain meaning of the  
8 term "directly attributable" requires that providers demonstrate a  
9 cause for increased per-treatment costs that is immediate, as  
10 opposed to remote. The plain meaning, however, could also require  
11 that providers demonstrate a cause for increase per treatment that  
12 is exact and precise. Plaintiff's argument, that the Court owes no  
13 deference to Defendant's interpretation of the regulation and  
14 phrase "directly attributable" because they are plain on their  
15 face, fails.

16 Plaintiff's argument that Defendant's interpretation of  
17 "directly attributable" is unreasonable is similarly unpersuasive.  
18 Plaintiff states that Defendant requires providers to submit  
19 documentation that incrementally links the particular cost item to  
20 the atypicality of patients in order to show that increased costs  
21 are directly attributable to an atypical patient mix. According to  
22 Plaintiff, general Medicare cost reporting principles do not  
23 require that providers directly link certain costs with the precise  
24 service rendered and, thus, Defendant's interpretation is  
25 unreasonable.

26 The Court, however, finds that Defendant's stringent  
27 definition of "directly attributable" is not inconsistent with the  
28

1 prospective rate reimbursement scheme Congress designed to create  
2 more efficient delivery of dialysis services, or with any Medicare  
3 regulation or provision. Plaintiff's definition, under which a  
4 provider's costs would be deemed "directly attributable" to its  
5 atypical service intensity as long as the provider demonstrated  
6 more than just a tenuous causal relationship between its increased  
7 costs and atypical patients, is inconsistent with Congress' intent  
8 to revamp the former reasonable cost system and implement a cost-  
9 savings system, under which exceptions are warranted only in  
10 unusual circumstances. Because Plaintiff does not show that  
11 Defendant's interpretation of "directly attributable" and  
12 "specifically attributable" is unreasonable or inconsistent with  
13 the plain meaning of the phrases, the Court finds that Defendant's  
14 interpretation, albeit exacting, is entitled to deference.

15 II. Labor costs

16 In its exception request, Plaintiff projected that it would  
17 incur a total of \$137.67 in labor costs per treatment, attributable  
18 to its atypical service intensity. These additional labor costs  
19 include salary and employee benefits for registered nurses, and for  
20 a nursing supervisor, clinical dietitian, unit assistant and  
21 physician medical director. Plaintiff argues that Defendant's  
22 denial of the majority of Plaintiff's requested amount was  
23 arbitrary and capricious because Defendant used an improper  
24 methodology to calculate nursing salary costs, refused to include  
25 any labor costs for Plaintiff's non-nurse employees, and limited  
26 Plaintiff's employee benefits costs based on an unsupported  
27 national average for employee benefit costs.



1 caring for its atypical patients. The final decision stated that,  
2 while Plaintiff "identified its actual and projected costs," it  
3 "failed to identify or document the incremental costs associated  
4 with the additional items or services rendered." AR 11.

5 Concluding that Plaintiff failed to provide written justification  
6 supporting its higher labor costs, Defendant denied all additional  
7 labor costs Plaintiff incurred for nursing supervision, unit  
8 assistants, a clinical dietitian and a physician medical director.

9 Plaintiff's contention, that its non-nurse salary costs are  
10 attributable to its atypical service intensity and thus should be  
11 reimbursed, rests largely on its argument that "directly  
12 attributable" does not require a provider to link the incremental  
13 labor costs at issue with its atypical patient mix. That argument,  
14 however, is unpersuasive; it again ignores the deference this Court  
15 must give to Defendant's interpretation of the regulations.

16 Plaintiff points to evidence that it claims shows that its  
17 excess labor costs are directly attributable to its atypical  
18 patient population, but that evidence is not clear and convincing  
19 or objective. Rather, it consists of conclusory statements that,  
20 because Plaintiff sees more atypical patients, it has higher  
21 management and administrative salary costs. While it seems likely  
22 that such is the case, Plaintiff failed to provide data to  
23 demonstrate that increased direct nurse service hours also required  
24 increased management and administrative support.

25 Defendant's decision regarding non-nursing labor costs was not  
26 arbitrary, capricious, unreasonable or contrary to the law, and,  
27 therefore, it cannot be overturned.

1 C. Employee benefits

2 Plaintiff sought to recover employee benefits at the level it  
3 pays: 24.59 percent of total salary. Defendant, however, found  
4 that Plaintiff failed to prove that any benefit percentage in  
5 excess of the 18.7 percent national average is attributable to  
6 Plaintiff's atypical patient mix. Therefore, Defendant limited  
7 Plaintiff's employment benefit reimbursement to the 18.7 percent  
8 national average. Plaintiff contends that this is improper for  
9 several reasons, none of which is persuasive.

10 Plaintiff relies on University of Cincinnati v. Shalala, 867  
11 F. Supp 1325 (S.D. Ohio 1994). In University of Cincinnati, the  
12 court found that, because the plaintiff did not demonstrate that  
13 its atypical patient mix exacerbated its employee benefits, it was  
14 not arbitrary, capricious, an abuse of discretion or contrary to  
15 law for the Secretary of Health and Human Services to limit the  
16 plaintiff's fringe benefits reimbursement to the national benefits  
17 average. 867 F. Supp. at 1331. But the court did find that the  
18 Secretary's unjustified use of 18.7 percent as the national average  
19 was arbitrary and capricious; the figure had not changed for over a  
20 decade. Id. at 1332. The court remanded the question to HCFA to  
21 determine and apply a national benefits average that was "more  
22 appropriately time-based." University of Cincinnati v. Shalala,  
23 1995 WL 599188 (S.D. Ohio 1995).

24 Defendant reports that, on remand, the HCFA re-evaluated the  
25 18.7 percent employee benefits rate and found it still valid. See  
26 Palomar Medical Center, CCH Medicare and Medicaid Guide, ¶ 56,546  
27 (CMS Admin. Dec. Oct. 2, 1997). Plaintiff does not deny this

1 finding. Nonetheless, it argues that, because the HCFA's re-  
2 evaluation decision was not part of the administrative record, it  
3 is not properly before the Court. Judicial review of agency action  
4 is generally limited to review of the record on which the  
5 administrative decision was based. The Ninth Circuit, however, has  
6 recognized exceptions to that general rule, including reviewing  
7 additional material to explain the basis of the agency's actions  
8 and the factors the agency considered. Love v. Thomas, 858 F.2d  
9 1347, 1356 (9th Cir. 1988). The Court considers the HCFA's re-  
10 evaluation of the 18.7 percent national average. Plaintiff's  
11 argument, that the 18.7 percent employee benefits rate is arbitrary  
12 and capricious because it is stale, is unavailing.

13 Plaintiff has failed to prove that Defendant's decision on  
14 this point was arbitrary, capricious, unreasonable or contrary to  
15 the law. Nor did Plaintiff show that Defendant's decision was  
16 unsupported by substantial evidence. Therefore, the Court cannot  
17 overturn Defendant's determination of employee benefits costs.

### 18 III. Overhead costs

19 Plaintiff projected that it would incur \$239.66 in overhead  
20 costs per treatment, almost \$200 above the composite rate, for  
21 laundry and linen, extra square footage, equipment depreciation and  
22 administrative and general costs. The Administrator found that  
23 Plaintiff failed to offer documentation, other than general  
24 statements, to link its higher overhead costs to its atypical  
25 patient mix. Because Plaintiff did not directly attribute its  
26 overhead costs to its atypical patient mix, Plaintiff's exception  
27 request for overhead costs was denied in its entirety.

1 Plaintiff contends that this decision was erroneous because  
2 Plaintiff proved that all of the increased overhead costs it sought  
3 were "directly attributable" to the atypical services it provides  
4 to its atypical patients. Plaintiff, however, uses a different  
5 definition of "directly attributable" than that employed by  
6 Defendant, and, as noted above, Plaintiff fails to show that  
7 Defendant's definition, placing a high burden on providers, is not  
8 entitled to deference.

9 Section 2725.1 of the Provider's Reimbursement Manual  
10 provides:

11 Overhead Costs -- There are infrequent instances, (i.e.,  
12 hepatitis) when an isolated area is required and where higher  
13 overhead costs may be justifiable. For those costs to be  
14 considered under this exception criteria, documentation must  
15 be submitted that identifies the basis of higher overhead  
16 costs, the specific cost components to be impacted and the  
17 incremental pretreatment costs. General statements regarding  
18 a facility's higher overhead costs are not acceptable in  
19 meeting the criteria.

20 Plaintiff argues that, to the extent this provision requires  
21 incremental cost attribution with respect to overhead costs, it  
22 must be disregarded as inconsistent with ESRD payment regulations.  
23 But it fails to show that this provision, or requiring incremental  
24 cost attribution with respect to overhead costs, is inconsistent  
25 with ESRD payment regulations. Although this provision in the  
26 manual "does not have the binding effect of law or regulation," the  
27 Court considers it as "clarifying existing regulations." National  
28 Medical Enterprises v. Bowen, 851 F.2d 291, 293 (9th Cir. 1988).

29 Relying on County of Los Angeles v. Sullivan, 969 F.2d 735,  
30 740-41 (9th Cir. 1992), Plaintiff further argues that Defendant's  
31 denial of all of its overhead costs violates the prohibition

1 against cost-shifting. By statute, Defendant is required to  
2 promulgate reimbursement regulations which assure that the  
3 necessary costs of efficiently delivering covered services to  
4 patients covered by Medicare "will not be borne by individuals not  
5 so covered." 42 U.S.C. § 1395x(v)(1)(A). County of Los Angeles,  
6 however, is distinguishable. Plaintiff's argument that Defendant  
7 violated the prohibition on cost-shifting is not persuasive.  
8 Nonetheless, as the Court discusses below, denying all  
9 administrative and general costs is arbitrary and an abuse of  
10 discretion, even if it does not violate the prohibition on cost-  
11 shifting.

12 A. Laundry and linen

13 Plaintiff contends that it demonstrated that it uses more  
14 linen and laundry than a typical dialysis facility because of its  
15 atypical patients. In its exception request, it stated:

16 Nearly half of our patients have problems with bowel/bladder  
17 disfunction; half of our patients required dressing changes at  
18 some time during the treatment; half of our patients were  
19 dialyzed with some sort of vascular access other than the  
20 normal fistula which resulted in excess blood on surfaces on  
21 the bed or chair; 79% of our patients were beset with vomiting  
during the treatment. All of these atypical problems resulted  
in the use of 6 to 10 times more linens than the typical  
dialysis population. Therefore, our laundry and linen amount,  
which may be 6 to 10 times that of the typical cost for this  
item, is justified.

22 AR 540.

23 Defendant points out that this general statement does not  
24 quantify the extent to which increased costs were incurred, nor  
25 does it provide detailed objective evidence and specific cost  
26 components. While it seems likely that Plaintiff indeed incurs  
27 atypical laundry and linen expenses, it does not identify any

1 evidence in the record quantifying these costs. Instead, it argues  
2 that Defendant's approval of its request for excess supply costs  
3 demonstrates that Defendant's denial of its request for excess  
4 linen and laundry costs is arbitrary. Plaintiff's request for  
5 excess supply costs, however, contains evidence quantifying  
6 Plaintiff's additional costs for gloves and linking the additional  
7 cost to Plaintiff's atypical patients. While Plaintiff contends  
8 that its cost for linen and laundry was \$23.55 per treatment, it  
9 fails to analyze or break down the specific cost components, or the  
10 corresponding incremental per-treatment costs, as required.

11 The Court finds that Defendant's decision denying an exception  
12 for laundry and linen costs was not arbitrary, capricious, an abuse  
13 of discretion or contrary to law.

14 B. Square footage

15 Plaintiff argues that it demonstrated that its dialysis unit  
16 requires more space than a typical dialysis unit because of the  
17 atypical nature of its patient population. For example, many of  
18 its patients have psychological and behavior disorders which  
19 necessitate that they be isolated from the remaining patients;  
20 other patients require isolation for medical reasons, such as  
21 chronic infection or acute complications such as diarrhea.

22 Therefore, Plaintiff has a separate isolation room, which contains  
23 a bed for treatment for these patients. Other patients are unable  
24 to sit up in a dialysis chair and require a bed, which takes up  
25 more space in a dialysis area than a chair.

26 Defendant does not dispute that Plaintiff's ESRD unit utilizes  
27 more space than a typical unit. Nonetheless, Defendant denied  
28

1 Plaintiff any excess overhead cost based on its extra square  
2 footage because Plaintiff failed to quantify specifically the  
3 difference in space, such as the space needed for the isolation  
4 room or for a bed as opposed to a dialysis chair.

5 Plaintiff does not argue that, with respect to excess square  
6 footage costs, it identified "the basis of higher overhead costs,  
7 the specific cost components to be impacted and the incremental  
8 pretreatment costs," as required by section 2725.1.B.4 of the  
9 Provider's Reimbursement Manual. Rather, it again argues that  
10 Defendant is requiring providers to comply with a too-stringent  
11 definition of "directly attributable." Defendant has put in place  
12 an exacting standard providers must meet in order to receive an  
13 exemption; this standard applies to overhead costs based on square  
14 footage. As explained above, because Defendant's standard is  
15 neither contrary to the plain language of the regulation nor to  
16 Congressional intent, the Court must afford it deference.  
17 Defendant's decision denying an exception for overhead costs based  
18 on square footage was not arbitrary, capricious, an abuse of  
19 discretion or contrary to law.

20 C. Capital equipment depreciation

21 Plaintiff argues that it demonstrated that it utilizes more  
22 expensive equipment than a typical unit due to its atypical patient  
23 population; unlike typical dialysis patients, Plaintiff's atypical  
24 patients routinely require the use of EKG machines, infusion pumps  
25 for antibiotics or chemotherapy and cardiac monitors. Again,  
26 Defendant does not dispute that Plaintiff incurred higher costs for  
27 this equipment. Defendant instead responds that, as noted by the  
28

1 intermediary, Plaintiff failed to submit "an incremental analysis  
2 of the breakdown of the equipment and the related depreciation  
3 expense which are required for typical and atypical patients." AR  
4 1002. Plaintiff does not refute this.

5 The Court finds that Defendant's decision denying an exception  
6 for overhead costs based on capital equipment depreciation was not  
7 arbitrary, capricious, an abuse of discretion or contrary to law.

8 D. Administrative and general

9 Plaintiff explains that administrative and general costs are  
10 those related to the operation of health care facilities and  
11 include such items as accounting, billing, administrative salaries  
12 and insurance. Plaintiff contends that it is entitled to  
13 additional administrative and general costs as part of its  
14 exception request because its ESRD unit incurs increased direct  
15 costs as a result of its treatment of atypical patients. According  
16 to Plaintiff, under Medicare rules, administrative and general  
17 costs follow direct costs and, therefore, it did not need to make  
18 an additional showing to link the administrative and general costs  
19 to the atypical patient services provided.

20 Defendant disagrees. He argues that requiring Plaintiff to  
21 prove independently that its excess administrative and general  
22 costs are directly attributable to its atypical patient mix is not  
23 contrary to the law. The Court finds that Defendant's decision  
24 denying any exception for administrative and general expenses  
25 overhead expenses is arbitrary and an abuse of discretion. As the  
26 Board explained, administrative and general costs are residual  
27 costs, not specifically and reasonably identified with any

1 particular area of a provider's operation. Some of Plaintiff's  
2 increased administrative and general costs are undoubtedly, and  
3 undisputedly, directly attributable to its atypical patient  
4 population.

5 Unlike Defendant's refusal to grant any exception for excess  
6 administrative and general costs, the Board's approval of a 56.5  
7 percent overhead exception amount for all approved direct cost  
8 exception amounts is reasonable. The Board based this decision on  
9 its reasonable assumption that the \$47 composite amount for  
10 overhead costs represents general and administrative costs incurred  
11 by ESRD facilities and was calculated in accordance with long-  
12 standing Medicare principles. Thus, it would be reasonable and  
13 non-arbitrary for Defendant to award Plaintiff a 56.5 percent  
14 overhead exception amount for all approved direct cost exception  
15 amounts, which would amount to \$50.63.

16 The Court remands this action to Defendant to determine an  
17 exception for administrative and general costs that is reasonable  
18 and non-arbitrary.

19 IV. Granting less than \$250 per treatment

20 Lastly, Plaintiff argues that it is entitled to continue  
21 receiving \$250 per treatment, as it has since 1987. Noting that it  
22 continues to serve the same atypical patient mix, Plaintiff  
23 contends that its costs have increased since 1987 and, therefore,  
24 Defendant's decision to reduce Plaintiff's payment below \$250 per  
25 treatment was erroneous, arbitrary and capricious.

26 Defendant responds first that Federal Rule of Evidence 408  
27 requires exclusion of the evidence of the \$250 payment rate because  
28

1 that rate was awarded as the result of a settlement. Rule 408  
2 provides that evidence concerning an offer to compromise, or  
3 acceptance of an offer to compromise, is not admissible "to prove  
4 liability for or invalidity of the claim or its amount." Plaintiff  
5 contends that the evidence is admissible because it is offered to  
6 show that Defendant's decision was arbitrary and capricious, not to  
7 prove liability.

8 Even if it is considered, the \$250 rate does not assist  
9 Plaintiff. As Defendant notes, there is nothing in the regulatory  
10 scheme that allows an exception rate to have any force after the  
11 applicable period expires. Plaintiff must prove by "clear and  
12 convincing objective evidence" that its excess costs are reasonable  
13 and allowable and directly attributable to its atypical patient  
14 mix. Plaintiff cannot prove that by pointing out that it  
15 previously received \$250.

16 Therefore, the Court will not overturn Defendant's decision on  
17 this ground.

#### 18 CONCLUSION

19 For the foregoing reasons, Plaintiff fails to demonstrate that  
20 Defendant's final decision was arbitrary, capricious, an abuse of  
21 discretion or otherwise not in accordance with the law, except with  
22 respect to Defendant's calculation for nursing salary costs and his  
23 denial of all administrative and general costs. Therefore, the  
24 Court affirms the final decision on Plaintiff's ESRD rate exception  
25 request in part and overturns it in part.

26 Both Plaintiff's Motion for Summary Judgment (Docket No. 13)  
27 and Defendant's Cross-Motion for Summary Judgment (Docket No. 17)

1 are GRANTED IN PART and DENIED IN PART. Specifically, the Court  
2 finds that Plaintiff is entitled to an exception amount of \$62.13  
3 for nursing salaries, \$15.80 per treatment more than the \$46.33  
4 approved by Defendant. This raises Plaintiff's Medicare  
5 reimbursement rate to \$228.61 per treatment. In addition, the  
6 Court finds that Plaintiff is entitled to an exception for its  
7 administrative and general overhead costs. It would be reasonable  
8 for Defendant to award Plaintiff a 56.5 percent administrative and  
9 general overhead exception amount, totaling \$50.63, for all  
10 approved direct cost exception amounts. The matter, however, is  
11 remanded to Defendant to calculate an exception for administrative  
12 and general overhead costs that is reasonable and non-arbitrary.  
13 Judgment shall enter accordingly. Each party shall bear its own  
14 costs.

15 IT IS SO ORDERED.

16 Dated: 10/17/06



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CLAUDIA WILKEN  
United States District Judge